BRIEFING MEMO

THE WHITE HOUSE

Washington

April 21, 2009

FROM: Nancy-Ann DeParle

SUBJECT: Health Reform Decisions

The purpose of this memorandum to is provide you with an update on health reform efforts and to prepare you to meet with your principal advisors, during which we will seek your guidance and direction about a number of key issues. We will also seek your authority to discuss with Congressional leaders the offsets that the Administration could *accept* in a health care reform proposal, as well as the options that the Administration would *encourage* Congress to include.

Background

Your advisors have been meeting regularly to discuss various aspects of your health reform plan, including its costs and financing. We are engaging actively with Congress and providing technical assistance to staff as they prepare for markups of bills. Your Budget included a down payment of about $630 billion over 10 years, and explicitly recognized that additional resources would be needed, so this effort is a natural outgrowth of your Budget proposal.

We have been developing a set of savings and revenue options to prepare to engage with Congress on financing health reform over the next few weeks. These options were presented to your senior staff, and we have developed a package that could plausibly offset the cost of health reform, consistent with the Administration's commitment to finance health reform without increasing the deficit.

The following summarizes the current state of play in Congress on the major policy issues:

- Individual requirement (i.e., mandate): Both the Senate and House include an individual requirement. Your campaign plan included a mandate for parents to cover their children, but not for adults; toward the end of the campaign, you expressed a willingness to consider an individual requirement if necessary to achieve universal coverage.

- Employer requirement (i.e., "pay or play" or "employer mandate"): Both the Senate and House are exploring this, primarily for revenue. The Senate is likely to include a small business tax credit.

- Insurance exchange: Both the Senate and House include a national exchange that may allow States to opt out. The Senate limits participation to individuals and small employer groups; the House is considering allowing large employers and others to participate.

- Public plan: Both include a public plan, although the Senate version is likely to be weaker.

- Benefits: The House wants minimum benefit package at FEHBP Blue Cross/Blue Shield Standard level, but realizes this may not be affordable; the Senate benefit package is less generous.

- Subsidies: Both the House and Senate support income-related subsidies for purchases of insurance through the exchange.

- Medicaid: The House wants to expand Medicaid eligibility for adults to 100 percent of poverty, fully Federally funded; the Senate has discussed requiring States to pay a share of this expansion.

- Financing: The Senate is considering a cap or elimination of the tax exclusion for employer-sponsored insurance, as well as other revenue options such as a high-income tax surcharge and a tax on sugar-sweetened beverages or "junk" food. The House is likely to include more Medicare cuts and is exploring other revenue options (though not currently discussing the tax exclusion cap, a step that Chairman Rangel among others has been skeptical of).

Options for Expanding and Improving Coverage

We have modeled the elements of your health reform plan using different assumptions to determine the cost and number of uninsured who obtain coverage. At the lower end of the spectrum, a conservative plan that covers half of the uninsured could cost around $900 billion over 10 years. At the other end of the spectrum, a generous plan that covers virtually all of the uninsured could cost nearly $2 trillion. This section outlines the key policy issues that will have a significant impact on the cost of any health reform plan: (1) inclusion of an individual requirement; (2) degree of choice of providers; (3) generosity of subsidies and benefits; (4) share of new costs assumed by States; and (5) phase-in schedule for implementation. While other issues (e.g., design of the public plan) may be substantively and politically important, they are unlikely to have a significant impact on the cost of a plan. Below, we describe each issue and its policy and cost implications and trade-offs.

Individual Requirement for Health Insurance

Your campaign plan included a requirement for parents to cover children but not an individual requirement for adults, in part because you expressed concern about affordability of premiums

for families. Based on our policy analysis, we believe that a weak requirement for all Americans to have insurance may come close to achieving the maximum coverage that can be achieved through aggressive outreach and auto-enrollment. Unfortunately, however, the Congressional Budget Office (CBO) will likely take the position that without an individual responsibility requirement, half of the uninsured will be left uncovered. This reduces federal costs – by roughly $270 billion over 10 years – but also reduces coverage (insuring only 28 of the projected 56 million uninsured in 2014). Those left uninsured tend to be either low cost (e.g., young adults) or have high income.

Because of concerns about the impact of the individual requirement on middle income families, we have explored coupling an individual requirement with an exemption process for those for whom coverage remains unaffordable. In Massachusetts, taxpayers are exempt from the mandate-associated penalties if the lowest premiums available to them exceed a certain fraction of income (for example at $60,000 of family income, families are excused from penalties if premiums exceed $4,400 – about 7 percent of income). There is an additional waiver process that allows people to claim a hardship exemption from the penalty on a case-by-case basis if they have special circumstances. Massachusetts has exempted 2.5 percent of adult tax-filers from the mandate requirement via these waivers.

Choice of Providers

One way to drive down prices and increase quality is HMO-type selective contracting, whereby insurers target their coverage policies and cost sharing to providers in a designated network. This could achieve up to 10 percent savings in the system, the equivalent of roughly $100 billion over 10 years. However, a more limited provider network would be viewed as more restrictive than that of FEHPB, which provides some coverage for out-of-network providers. This raises a concern in that most public opinion research has found that Americans highly value a choice of doctors.

Generosity of Subsidies and Benefits

Most of the Federal cost of health reform is concentrated among low-income people who could not otherwise afford health insurance. To date, we have assumed that people with income below the poverty level would be placed in Medicaid and pay no premiums, and those with somewhat higher income would receive a sliding-scale tax credit. Specifically, tax credits would ensure that premiums would be limited to a range of 2.5 percent to 12.5 percent of income. The level of the subsidies matters: moving to a more generous scale dramatically increases costs. However, scaling back the subsidies runs a risk of creating a large "tax" on low-income individuals if coverage is required for all.

The generosity of the benefits package affects costs, as well, both for the Federal government and for individuals and families. Your advisors have looked at several benefit packages

available in the employer-based market. Because of our concern about affordability, we are focusing on benefits packages commonly available in the small group market. Such plans typically cover hospital and physician services and prescription drugs as well as offer preventive services and pediatric care with no cost sharing. This benefit package covers the same services as FEHBP, but with higher cost-sharing. To compensate for their more limited means, low-income individuals would have lower cost-sharing obligations.

A distinct question regarding subsidies and benefits relates to people whose income is below the Federal poverty level (i.e., $24,095 for a family of four). While we have assumed that they would be enrolled in Medicaid, we could either enroll them in the exchange or limit the benefit package in Medicaid as a means of reducing costs. Compared to private plans, Medicaid payment rates are about 5 percent lower and benefits are about the same percent higher. As such, there is only a small cost effect of enrolling poor people in the exchange. Savings could also be achieved by limiting States' ability to access Federal matching payments for optional services like dental care or long-term care. However, this would be controversial since these individuals likely would either forego care or cost shift to providers.

State Share of Costs

Currently, States spend nearly $140 billion, and the Federal government spends $181 billion annually, on Medicaid. If our policy expands Medicaid to cover the 13 million people below the poverty level, the Federal government could assume 100 percent of the expansion, or states could be asked to pay some share. If, for example, the CHIP matching rate formula were applied to the newly-eligible poor people enrolled in Medicaid, Federal costs would decline by nearly $220 billion over 10 years. However, States may object to this as an unfunded mandate, and, depending on its design, the policy could result in many winners and losers. We are exploring options to minimize the burden on States through other policy changes that could reduce their Medicaid costs.

Phase-In

One area for exploration is whether the exchange, tax credits, Medicaid expansion and/or individual responsibility requirements should be phased-in. Phasing-in makes sense on a number of dimensions, beyond cost. It would limit disruption and allow time for States and other actors to adjust to the new system. It would also reduce Federal costs in the budget window – although it would not affect the ultimate, annual cost of health reform. Without a coverage requirement, health reform costs are always higher than expected because the first people to enter any voluntary system are those that need it the most, and thus have the highest cost. This could cause adverse selection in the health exchange and throw the new system off track. As such, phasing-in health reform is tricky.

Options for Financing Health Reform

The table below shows how a universal or near-universal health insurance proposal could be offset. In the Budget, the Administration proposed a reserve fund of about $630 billion over 10 years in potential savings and revenue options. Over the past several weeks, we have identified approximately $300 billion in additional savings over 10 years (primarily in Medicare), and about $500 billion over 10 years in additional revenue options that are consistent with your principles.[1] We believe that this package represents a credible set of proposals to discuss with Congress, although there are always challenges in enacting Federal Medicare savings and revenues of this magnitude.

$ in trillions	10-year Estimate
Possible Cost of Health Reform	$1.4
Reserve Fund in Budget	-$0.6
Federal savings [non-add]	*-$0.3*
New revenue [non-add]	*-$0.3*
Potential Additional Medicare Savings	-$0.3
Potential Additional Revenues	-$0.5
Potential Funding Gap	$0.0

The potential additional offsets -- beyond your budget proposals -- fall into one of three categories: savings options, "game changers," and revenue options.

Savings Options

The following proposals reduce Federal outlays within the existing health system's structure, but do not purport to fundamentally transform it. These options may not improve the delivery of care or efficiency of the system as much as game changers might, but they provide scorable savings and are solid policy.

- Medicare market basket adjustments for expected productivity improvements. Productivity in the U.S. economy has been improving over time. Medicare payments have not been adjusted to reflect the system-wide improvement. This proposal would reduce annual Medicare payment updates by a factor to reflect better economy-wide productivity. This proposal could produce savings in the range of $134 billion over 10 years.

[1] All savings estimates are preliminary staff estimates.

- Extend Medicaid drug pricing to dual-eligible beneficiaries under Medicare Part D. This proposal could produce savings in the range of $30-$50 billion over 10 years and has generated interest from Chairmen Waxman and Baucus.

- Combine and reduce Medicare/Medicaid Disproportionate Share Hospital (DSH) payments into an uncompensated care assistance fund to hospitals to reflect an increase in coverage due to health reform. This proposal could produce savings in the range of $85 billion over 10 years.

Options to Reduce Long-Term Cost Growth

The set of proposals that we have come to refer to as "game changers" are proposals that your advisors believe have the potential to reduce the long-term cost growth of health care. Unfortunately, these proposals may not be scored by CBO as producing savings because the effects of the policy are hard to quantify and/or there has been limited experience with the intervention. Proposals of this sort include the following:

- Reduce Medicare's payment rate for hospitals with a high volume of elective admissions. Hospitals that have high utilization rates would face a reduction in payments to encourage them to reduce unnecessary care.

- Promote Efficient Use of Technology/Limit Low-value Diffusion. Technology is one of the largest cost drivers of long-term health care costs. This proposal would promote a range of options from certificate of need regulations, research initiatives for high-value technology, linking technology to payments, and interactions with Comparative Effectiveness Research to encourage the adoption of efficient technology while limiting use of technology that does not provide sufficient value.

- Registries for devices and drugs. HHS would be directed to take steps necessary to establish registries for devices and drugs to follow patient experiences with these products. Registries would provide post-FDA approval patient experience with drugs and devices to continue evaluation of safety and efficacy over time, as well as potentially compare new products.

Revenue Options

Options generating new Federal revenue complement those aiming to reduce Federal spending. In developing these proposals, we have sought to raise substantial new revenues without increasing taxes on the middle class.

- Require employer shared responsibility. Employers with annual payroll above $1 million that do not offer health insurance and meaningfully contribute to quality health care (e.g., the House is considering a minimum employer contribution equal to 75 percent of the

premium) would be required to pay 6 percent of their payroll to the Federal government to help defray the costs of subsidies for their employees to obtain coverage via the insurance exchange. Initial estimates suggest that this option could provide revenue of $20 billion over 10 years.

- Impose a 10-cent excise tax on sugar-sweetened beverages. This proposal would impose a Federal tax on most soda and other sugar-sweetened beverages. It is estimated to generate revenue of about $170 billion over 10 years.

- Create a high-income surcharge for health care reform. Individuals with annual income over $500,000 and families with incomes over $1 million would pay a 3 percent surcharge. This option would produce revenue in the range of $220 billion over 10 years.

In addition, Chairman Baucus is considering incorporating some version of the proposal to cap the exclusion of health benefits from Federal taxation into the Senate Finance bills.

Conclusion

We will be discussing these issues in further detail at the meeting with your senior advisors and will be looking for guidance from you.